Hospital Change Plan

Key:	Required Outcomes are in **BOLD**
	Recommended Tactics are indicated with an * and in BLUE
	For the purposes of MTP, the term "Behavioral Health" as defined by Washington State Health Care Authority (HCA) encompasses both Mental Health and Substance Use Disorder (SUD) services.

Domain	Focus Area	Outcome	Check O 'X'	Start Date	Target Date	Tactics	Check T 'X'	Notes
1. Care Coordination	1. Population Health Management	A. Population-based platform is systematically utilized to follow subpopulations for more efficient and effective care				* 1. Standardize identification of and track sub-populations needing more efficient management and effective care based on conditions and/or risk levels		
						a) Substance Use Disorder		
						b) Opioid Use Disorder		
						c) Co-occurring Mental health and Substance Use Disorder		
						~~d) Behavioral health and chronic disease~~		
						~~e) Depression~~		
						~~f) Pediatric oral health~~		
						~~g) Adult oral health~~		
						~~h) Asthma~~		
						~~i) Diabetes~~		
						~~j) Hypertension~~		
						~~k) Cardiovascular disease~~		
						~~l) Historical trauma and Adverse Childhood Experiences (ACEs)~~		
						~~m) Women of childbearing age (15-44)~~		
						~~n) Children overdue for well-child visits~~		
						~~o) Children under 2 who are not up-to-date with immunizations~~		
						* p) High utilizers of the ED		
						q) High utilizers of the criminal justice system		
						r) Experiencing homelessness and/or food insecurity		
						s) Other		

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						4. Disaggregate patient/client data by subpopulations to identify and track inequities (race, gender, age, other)		
		B. Social determinants of health (SDOH) are assessed and integrated into standard practice				1. Train staff about the impacts of SDOH on health and using SDOH screening tool		
						2. Integrate SDOH screening tool in intake process and routine care		
						* 3. Patients/clients are screened for specific SDOH needs		
						a) Housing status/needs		
						b) Employment status/needs		
						c) Transportation status/needs		
						d) Food status/needs		
						e) Other		
		C. Care coordination protocols that include screening, appropriate referal, and closing the loop on referrals are developed to connect specific subpopulations to clinical or community services				1. Organization focuses on linking specific subpopulations to appropriate clinical or community services		
						~~a) Children who are overdue for well-child visits to primary care~~		
						b) Patients receiving treatment for substance use disorder or mental illness who have chronic disease to primary care		
						c) Patients post psychiatric stay, residential treatment, or ED visit related to overdose, substance use disorder, or mental illness to primary care and/or behavioral health care		
						d) Patients with housing, transportation, employment support, and food needs to community-based organizations		
						e) Families, women, and children to community-based organizations		
						f) Pregnant women to dental providers for dental care		
						g) Adults with diabetes to dental providers for dental care		

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						h) All patients/clients needing dental care to community dental providers, and/or mobile dental services		
						~~i) Coordinate with host agency to embed mobile dental services on site~~		
						j) Women in first trimester of pregnancy to prenatal care		
						k) Women with risky health behaviors (alcohol use, tobacco use, illicit drug use, disordered eating, etc.) to evidence-based community support programs and specialty care		
						l) Women with prior adverse pregnancy outcomes and women with other identified risks (including social determinants) to community-based programs that provide intensive services during the prenatal and interconception periods (NFP, Healthy Start)		
						m) Other		
						2. Offer referrals (verbal or written) to patients/clients informing where they can receive needed services		
						3. Sign Business Associate Agreements or equivalent with partners invovled with the patient's care to support referrals OR sub-contract with community partners to ensure shared patients/clients receive appropriate services		List Partner(s): _____
	2. Shared Care Management	**A. Streamlined process is in place for information to be shared in a timely manner for shared patients/clients**				1. Implement protocol to obtain shared patient/client records		
						* 2. Sign inter-organizational agreements for access to records of referred and/or shared patients/clients		List Partner(s): _____

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						3. Participate in a technology platform that allows necessary patient/client information to be exchanged between the referee and referral organization		
						5. Establish and document a protocol for convening cross-sector care meetings		
	3. ED Diversion	**A. At ED visit, patients are linked to a patient-centered medical home (PCMH) and appropriate services to treat mental health, substance use disorders and/or co-occurring disorders**				* 1. Implement process to link patients to their patient-centered medical home or primary care provider. If they do not have one, establish a new patient referral to a primary care provider		
						* 2. Implement process to link patients needing behavioral health services to a behavioral health provider		
						3. *Kitsap NCC:* Embed community health workers in the ED to link patients to a patient-centered medical home or primary care provider		
						* 4. Implement process to review the PRC (patient review and coordination) list and EDIE feeds, assess patient needs, and link patients to community providers		
		B. Organization develops or enhances services to help keep patients/clients out of ED				1. *Jefferson and Clallam NCC:* Community paramedics or EMTs perform home visits through a sub contractual relationship with your organization		
						2. *Jefferson and Clallam NCC:* Community paramedics or EMTs perform alternative transports through a sub contractual relationship with your organization		

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		C. Patients/clients are assisted to understand appropriate settings for receiving health care services including ED utilization				1. Provide information or education to patients/clients about appropriate care settings		
						2. Ensure patients and their caregivers have access to instructions on how to get advice after hours		
						3. Assign care managers to assist those with recurrent ED overuse to identify barriers to accessing primary care, identify solutions, and resolve issues		
		D. Providers are notified of patient/client ED visits				* 1. Establish notification system between hospital and patient's medical/behavioral health home within NCC when a patient/client visits the ED		
						2. Implement workflows to review Emergency Department Information Exchange (EDIE) feeds		
3. Care Transformation	1. Opioid Misuse and Abuse Prevention	**A. Best practices for opioid prescribing are promoted and used**				1. Train providers on the Agency Medical Directors' Group's (AMDG) interagency or CDC guidelines on prescribing opioids for pain		
						2. Update all opioid prescribing protocols, policies, and patient agreements, train staff on them, and review them annually		
						3. Create standardized chronic opioid prescribing policies and care pathways		
						4. Standardize workflows for Chronic Opioid Therapy (COT)		
						5. Create a COT registry and assign staff member to ensure information is routinely updated		

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						6. Create a standardized approach for dealing with complex patients including an outline for patient-centered discussions		Population of Focus: _____
						7. Reconcile medications routinely to avoid unsafe combinations		
						8. Incorporate the use of the Prescription Drug Monitoring Program (PDMP) into workflow		
						9. Train prescribers in best practices for tapering from opioids		
						11. Adopt a standardized tool to adjust opioid dose based on function and quality of life rather than on pain scales alone		
						12. Standarize recording of morphine quivalent dose (MED) in patient charts whenever an opioid prescription or change to opioid prescription is made		
						13. Clinic leadership uses data to monitor and improve provider prescribing practices		
		B. Providers are trained to recognize potential for opioid use disorder (OUD) and utilize a standardized protocol for screening and referring these patients				1. Educate providers across all health professions on how to recognize signs of opioid misuse and OUD among patients and how to use appropriate tools to identify OUD		
						2. Identify patients on COT during morning huddle and address care gaps		
						3. Create opportunities for staff to discuss challenging patients on COT		

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		C. Capacity is built to prevent OUD				1. Deliver care via telehealth in rural and underserved areas to increase capacity of communities to support OUD prevention and treatment		
						3. Offer or arrange for alternatives to opioids to relieve pain		
		D. Patients are engaged around prevention of OUD				4. Review safe storage of opioids with patients		
						5. Refer all patients with narcotic prescriptions to safe medication return and disposal programs (also called “drug take back”)		
		E. Public is offered education and awareness around opioid epidemic				1. Link to public awareness programs such as It Starts with One		
						2. Use local data to raise awareness of regional impact of opioid epidemic		
	2. Opioid Overdose Prevention	**A. Naloxone is accessible**				1. Co-prescribe naloxone for patients on opioid medication as best practice per AMDG guidelines		
						* 2. Provide overdose education, peer support and take-home naloxone to individuals seen in the ED for opioid overdose		
						3. Train staff to recognize and appropriately respond to an overdose		
						4. Add prompts to EHR to encourage providers to prescribe naloxone to patients on high doses of opioids		
						5. Encourage patients on COT to involve caregivers to learn how to administer naloxone		

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						6. Co-prescribe naloxone with medication-assisted treatment (MAT)		
						7. Increase Naloxone access and distribution points		
						8. Develop policy to taper opioids safely after an overdose		
	3. Opioid Use Disorder Treatment	A. Full spectrum of evidence-based care for OUD is available				1. Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options		
						9. Develop regional standards of practice (adopt Bree OUD report and treatment recommendations)		
						11. Give pharmacists tools on where to refer patients who may be misusing prescription pain medication		
						12. Enhance referrals to syringe exchange program		
						13. Develop/support linkages between syringe exchange programs and physical health providers to treat any medical needs that require referral		
						14. Develop/support linkages between syringe exchange programs and behavioral health providers to treat any behavioral health needs that require referral		
						15. Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery		

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		B. Manage OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns				1. Implement the guideline Substance Abuse during Pregnancy: Guidelines for Screening and Management		
						2. Implement the Washington State Hospital Association Safe Deliveries Roadmap standards to health care providers		
						3. Educate pediatric and family medicine providers to recognize and appropriately manage newborns with neonatal abstinence syndrome (NAS)		
						4. Increase the number of obstetric and maternal health care providers permitted to dispense and prescribe MAT through the application and receipt of DEA approved waivers		
		D. Hospitals and primary care clinics partner with mental health and substance use disorder providers to deliver acute care and recovery services to patients with OUD				1. Formalize referral relationship through inter-organizational agreement with providers who offer these services		List Partner(s): _____
						2. Employ or contract with providers who offer these services		List partner(s):_____
						3. Create informal referral relationships with providers who offer these services		List partner(s):_____

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	4. Chronic Disease Prevention and Control	**C. Community-clinical linkages are enhanced to ensure patients are supported and active participants in their disease management**				* 1. Form bi-directional referral system within the Natural Community of Care between clinical and community partner for effective chronic care services such as Diabetes Prevention Program (DPP), Chronic Disease Self-Management (CDSM), Whole Health Action Management (WHAM), exercise programs, and/or other; refer to appropriate programs depending on patient profile		List partner(s):_____
						2. Maintain internal community resource list to provide ongoing self-management support to patients		
						3. Engage local health coalitions, to advocate for policies to improve patient care and to develop programs to address social determinants within community		
4. Care Infrastructure	1. Capacity Infrastructure	A. Access to care is increased				1. Ensure all patients eligible for health insurance are enrolled		
						2. Increase marketing and uptake of a patient portal; patient scheduling through patient portal		
						3. Expand dental care through capital campaign projects		
						4. Purchase operatories, supplies, and/or equipment to expand access to care		
						5. Host a mobile dental clinic		
						6. Operate a mobile dental clinic		
						7. Purchase, store, distribute, and dispose of expired naloxone appropriately		

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						8. Offer telehealth or telepsychiatry to patients where appropriate		
		B. Health information is exchanged securely, appropriately, timely, and efficiently				1. Explore a common or interoperable EHR (electronic health record) or EBHR (electronic behavioral health record) within Natural Community of Care		
						2. Explore a shared population health management system within Natural Community of Care		
						3. Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share		
		C. All staff understand the impact of trauma and health inequities on health				1. Offer training in health equity		
						2. Offer training in LGBTQ-inclusive care		
						3. Offer training in NEAR sciences, historical trauma, and trauma-informed care		
		D. Patients receive the care they need from a trained workforce				1. Share workforce with another organization		
						2. Partner with an institute to establish a residency training program		
						a) MD		
						b) DO		
						c) ND		
						d) ARNP		
						e) Other		
						3. Partner with community college programs to recruit allied health professionals as they graduate		
						4. Hire Community Health Worker or similar workforce		

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							a) Community Health Worker	
							b) Peer Advocate	
							c) Navigators	
							d) Other	
						5. Incorporate telehealth into your practice		
		E. Quality improvement methods are used to improve care and care delivery				* 1. Form and maintain a diverse quality improvement (QI) team of clinical and administrative staff with protected time to examine and improve upon clinical outcomes, quality of care, and patient satisfaction		
	2. Sustainability	**A. Transformation is sustained beyond the Medicaid Transformation Project**				* 1. Implement value-based payment arrangements with MCOs		
						* 2. Offer organization financial or in-kind match of DSRIP funding		
						* 3. Report on value-based metrics that will be in MCO contracts (not actionable until 2019, when providers will know which metrics will be in the contracts)		
						4. Support all-payer collaboration to foster system-wide transformation		
	3. Administrative	**A. Organization can exercise effective leadership, management, transparency and accountability of MTP activities throughout the duration of its Change Plan**				* 1. Establish and maintain an effective governance structure, and public access/reporting protocols regarding all MTP-related planning and decision-making		
						* 2. Implement reporting policies and practices to ensure complete and timely reporting of change plan activities to OCH		